General Assembly

Raised Bill No. 108

February Session, 2004

LCO No. **1107**

01107_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING APPEALS OF HEALTH CARE DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478n of the general statutes, as amended by section 94 of public act 03-278, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) **[**On or after January 1, 1998, any**]** Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization or utilization review company to appeal **[**a**]** the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner.

(b) (1) To appeal a **[**decision under the provisions of**]** denial or determination pursuant to this section **[**,**]** an enrollee or any provider acting on behalf of an enrollee shall, **[**within**]** not later than thirty days

[from] after receiving [a] final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by [said] the commissioner and shall include the filing fee provided for in subdivision (2) of this section and a general release executed by the enrollee for all medical records pertinent to the appeal.

(2) The filing fee shall be twenty-five dollars and shall be deposited [into] in the Insurance Fund established in section 38a-52a. If the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner shall waive the fee.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity as defined in subsection (c) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept [it] the appeal if such entity determines: (A) The individual was or is an enrollee of the managed care organization; (B) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee has exhausted all internal appeal mechanisms provided; (D) the enrollee has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization and any other relevant provider.

(5) Upon completion of the preliminary review, the entity conducting such review shall immediately notify the member or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons [therefore]

why the appeal was not accepted for full review.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with the provisions of chapter 54.

(c) To provide for such appeal the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide for medical review under the provisions of this section. Such review entities shall include (1) medical peer review organizations, (2) independent utilization review companies, provided any such organizations or companies are not related to or associated with any managed care organization and (3) nationally recognized health experts or institutions approved by the commissioner.

(d) (1) Not later than five business days after receiving a written request for any information set forth in this subdivision a managed care organization whose enrollee is the subject of an appeal shall provide to the enrollee, the enrollee's designee or the commissioner: (A) A copy of the entire policy or contract between the enrollee and the managed care organization, and (B) written verification of whether the enrollee's managed care plan is fully insured, self-funded, or otherwise funded.

(2) Failure of the managed care organization to provide a copy of the entire policy or contract within said five-day period or before the expiration of the thirty-day period for appeals set forth in subdivision (1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, for purposes of accepting an appeal pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service that is the subject of the appeal is a covered benefit under the applicable policy or contract and (B) entitle the Insurance Commissioner to require the managed care organization to reimburse the department for the

expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

[(d)**]** (e) The commissioner shall accept the decision of the **[**reviewing**]** review entity and the decision of the commissioner shall be binding.

[(e)**]** (f) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The Managed Care Ombudsman shall coordinate the outreach program and oversee the education process.

This act shall take effect as follows:	
Section 1	*October 1, 2004*

Statement of Purpose:

To revise external appeal provisions related to determinations made by managed care organizations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]